



BROWN SURGICAL ASSOCIATES
BROWN PHYSICIANS, INC.

Brown Surgical Associates General and Bariatric Surgery

Returning Patient Questionnaire:

*Please complete this questionnaire and bring it with you to your appointment with the practitioner.
This information will assist us in your care plan. Thank you.*

Full Name: _____ **Date of Birth:** _____

What are you here for today? _____

Please indicate any new illnesses or medical history:

Do you have pain that interferes with your daily activity? No Yes

If yes, where is the pain?

Please circle the number that represents your pain level:

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Do you exercise regularly? Yes No

Types of exercise? Strengthening Cardio Other: _____

How often? _____ times/week _____ times/month

If no, what prevents you from exercising?

Time Work Health Other: _____

Do you have any other health concerns today?



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Please indicate if you are **now experiencing** or **in the past year experienced** any of the symptoms listed below.

<p>GENERAL</p> <p><input type="checkbox"/> Weight Gain</p> <p><input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> Fatigue</p> <p>HEAD, EARS, EYES, NOSE, THROAT</p> <p><input type="checkbox"/> Eye Pain</p> <p><input type="checkbox"/> Red Eyes</p> <p><input type="checkbox"/> Dry Eyes</p> <p><input type="checkbox"/> Vision Problems</p> <p><input type="checkbox"/> Trouble Swallowing</p> <p><input type="checkbox"/> Pain with Swallowing</p> <p><input type="checkbox"/> Hearing Loss</p> <p><input type="checkbox"/> Nose Bleeds</p> <p><input type="checkbox"/> Dry Mouth</p> <p><input type="checkbox"/> Sore Throat</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Swollen Nodes</p>	<p>CARDIO-VASCULAR</p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Light Headedness</p> <p><input type="checkbox"/> Leg pain with exercise</p> <p><input type="checkbox"/> Leg swelling</p> <p>RESPIRATORY</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Painful Breathing</p> <p><input type="checkbox"/> Shortness of breath</p> <p style="padding-left: 20px;">With activity</p> <p><input type="checkbox"/> Sleep Apnea</p> <p>GASTRO-INTESTINAL</p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Heartburn/Reflux</p> <p><input type="checkbox"/> Nausea/Vomiting</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p>	<p>RENAL/REPRODUCTIVE</p> <p><input type="checkbox"/> Painful Urination</p> <p><input type="checkbox"/> incontinence</p> <p><input type="checkbox"/> Vaginal Discharge</p> <p><input type="checkbox"/> Abnormal Vaginal Bleeding</p> <p>MUSCULOSKELETAL</p> <p><input type="checkbox"/> Joint Pain</p> <p><input type="checkbox"/> Joint Stiffness</p> <p><input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> Muscle Pain</p> <p><input type="checkbox"/> Muscle Weakness</p> <p>SKIN</p> <p><input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> Skin wound</p>	<p>NEUROLOGIC</p> <p><input type="checkbox"/> Confusion</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Difficulty walking</p> <p>PSYCH</p> <p><input type="checkbox"/> Suicidal</p> <p><input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p>ENDOCRINE</p> <p><input type="checkbox"/> Bulging eyes</p> <p><input type="checkbox"/> Hot Flashes</p> <p><input type="checkbox"/> Muscle Weakness</p> <p><input type="checkbox"/> Voice Change</p> <p>HEME</p> <p><input type="checkbox"/> Easy Bleeding</p> <p><input type="checkbox"/> Easy Bruising</p> <p><input type="checkbox"/> Swollen Glands</p>
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Medications and Supplements: Check if no changes

Medication/Supplement	Dosage & Frequency	Reason